

## Trial of the CarePartner Program for Improving the Quality of Transition Support

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<b>Principal Investigator:</b>	Piette, John D., Ph.D., M.S.
<b>Organization:</b>	University of Michigan at Ann Arbor
<b>Mechanism:</b>	PAR: HS08-270: Utilizing Health Information Technology (IT) to Improve Health Care Quality (R18)
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**Summary:** Patients hospitalized with complex chronic conditions frequently experience preventable short-term readmissions due to a lack of coordinated care and inadequate support when they transition from the hospital to the home setting. Proactive, post-discharge followup by continual patient monitoring including caregiver support to manage their health and illness can reduce patients' rehospitalization risk and improve the quality of care during the hospital-to-home transition.

This study will evaluate the CarePartner (CP) intervention intended to improve the effectiveness of support for transitions from hospital to home for patients with common chronic conditions. The CP intervention uses low-cost health information technology (IT) and coordinated communication between patients' informal caregivers or "CarePartners" and their clinical teams to address their needs and manage their health. Patients in the CP intervention will receive comprehensive discharge planning for managing their chronic condition and coordinating their care across transitions. They will also receive direct, tailored monitoring and communication on self-care education via regular automated telephone calls post-discharge.

A randomized, controlled trial of 380 patients will compare those with common chronic conditions receiving usual discharge planning and post-discharge support to outcomes among patients receiving the CP intervention. Patients are being recruited from the University of Michigan Health System Medicine Inpatient Service and are asked to identify up to four potential CarePartners. CP intervention patients receive automated assessment and behavior change calls, and their CarePartner receives structured feedback and advice following each assessment. Patients' clinical teams have access to patients' assessment results via the Web and receive automated reports about urgent health problems. Patients complete surveys at baseline, 30 days post-discharge, and 90 days post-discharge to assess measures such as health service use, health-related quality of life, self-care behaviors, and understanding of the transition process. CarePartners complete surveys at baseline and 90 days post-discharge to evaluate factors such as CarePartner burden and satisfaction with the intervention. Data on inpatient and outpatient clinic visits will be abstracted from patient medical records to assess utilization, readmission, and mortality outcomes. The primary outcome of the trial is 30-day readmission rates. Secondary outcomes include functional status, self-care, and mortality risk.

The CP intervention targets multiple stakeholders and implements an innovative and scalable IT approach to promote successful care transitions by improving the effectiveness of patients' CarePartners, clinician followup, and self-management of health. This coordinated approach has potential to improve the quality

of care and success of care transitions among patients with common chronic conditions.

### Specific Aims:

- Determine whether the CP model for supporting effective transitions from hospital to home improves outcomes of care, including lower readmission rates, emergency department visits, and improved patient functional status. **(Ongoing)**
- Evaluate the impact of the intervention on process measures of transition quality and patients' medication-related self-management. **(Ongoing)**
- Determine whether the intervention increases the quality of life and quantity of support for patients' self-care using a mixed methods approach to identify whether service reduces caregivers' stress and increases their disease-specific communication with the patient. **(Ongoing)**

**2012 Activities:** The project team activities for 2012 involved preparing and opening the CP trial. The data collection tools and information management systems being used to track recruitment and enrollment in the trial were developed, institutional review board approval was obtained, staff were hired and trained, and the interactive voice response system being used in the trial was developed and tested. The CP trial opened to recruitment in late 2012 and will continue through the third year of the project.

As last self-reported in the AHRQ Research Reporting System, project progress and activities are mostly on track and the project budget spending is on target.

**Preliminary Impact and Findings:** This project has no findings to date.

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**Target Population:** Adults, Chronic Care\*

**Strategic Goal:** Develop and disseminate health IT evidence and evidence-based tools to support patient-centered care, the coordination of care across transitions in care settings, and the use of electronic exchange of health information to improve quality of care and self-management support.

**Business Goal:** Implementation and Use

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*\* This target population is one of AHRQ's priority populations.*